ADVANCE DIRECTIVES

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Both chapter 154 and chapter 155, Wis. Stats., allow a person 18 years of age or older the right to formulate advance directives for health care while s/he is of sound mind. An individual cannot autonomously formulate advance directives, under state statutes, if s/he is not of sound mind or did not formulate the advance directives while of sound mind.

Living wills executed under the statute allow a competent adult to authorize the withholding or withdrawal of life-sustaining procedures and non-oral nutrition and hydration (feeding tubes) when he or she has a terminal condition or is in a persistent vegetative state, unless the attending physician advises that this will cause pain or reduce the individual's comfort. The statute also allows oral nutrition and hydration to be withheld if the attending physician advises that administration of food or fluid is medically contraindicated.

Two physicians who have examined the individual (one of whom must be the attending physician) must certify in writing that an individual has a terminal illness and is near imminent death or in a persistent vegetative state.

Living wills executed under the statute do not allow an individual to authorize the withholding or withdrawal of non-oral nutrition or hydration (tube feedings), if such actions, in the judgement of the attending physician, will cause pain or reduce the individual's comfort level. Nor do they allow an individual to authorize the withholding or oral food and fluid unless the attending physician advises that administration is medically contraindicated.

Each person who voluntarily makes a living will must sign and date the living will in the presence of two witnesses who:

- are not related to the individual by blood or marriage;
- are not entitled to any portion of the estate of the individual under any will which s/he has drafted;
- have no claim against any part of the individual's estate at the time the living will is executed;
- are not, at the time the living will is executed, the attending physician, employees of the attending physician, the attending nurse, members of the attending medical staff, or employees of a hospital, nursing home, or community-based residential facility who are health care providers involved in the medical care of the individual. (Health care providers are defined as a licensed nurse, chiropractor, dentist, physician, podiatrist, physical therapist, occupational therapist, occupational therapy assistance, respiratory care practitioner, optometrist, acupuncturist, or psychologist, or a partnership or corporation of the above.) For living wills executed under the statute, no employe of an inpatient health care facility can be a witness to the signing of a living will.

If an individual is physically unable to sign his or her living will, the living will can be signed in the individual's name, at the express direction of the individual and in his or her presence, by a witness or another person appointed by the individual making the living will.

No physician, inpatient health care facility or health care professional acting under the direction of a physician can be held criminally or civilly liable, or charged with unprofessional conduct, for:

- carrying out an individual's directive to withhold or withdraw life-sustaining procedures *or tube feedings*;
- failing to act upon a revocation unless the person or facility had actual knowledge of the revocation; or
- failing to comply with a living will.

Effective with living wills executed under the revised 1991 statute, a qualified witness acting in good faith cannot be held criminally or civilly liable for participating in the withholding or withdrawal of life-sustaining procedures or tube feedings.

A physician who fails to comply with a living will of a patient may be charged with unprofessional conduct if s/he is aware of the living will, refuses to honor it, and fails to make a good faith attempt to transfer the patient to another physician who will comply with the living will.

Persons who willfully conceal, cancel, deface, obliterate or damage the living will of another without the individual's consent may be fined not more than $500 or imprisoned not more than 30 days or both. Persons who willfully conceal knowledge or evidence that a living will has been revoked or who illegally falsify or forge a living will, with the intent of causing life-sustaining procedures *or tube feedings* to be withheld or withdrawn contrary to the individual's wishes, may be fined not more than $10,000 or imprisoned not more than ten years, or both. (s. 154.15, Stats.)

The provisions in chapter 155, Stats. [Power of Attorney for Health Care], allow any person 18 years of age or older and of sound mind (referred to, in the statute, as a "principal") the right to designate an individual and/or a second individual (the "health care agent(s)") with power of attorney for health care. This gives the health care agent authority to accept, maintain, discontinue or refuse certain health care options if the individual is found to have an incapacity. Incapacity is evidenced by an unwillingness or inability to make health care decisions because the individual is unable to receive and evaluate information effectively or is unable to communicate decisions. The finding of incapacity must be made by two physicians, or one physician and one psychologist, who:

- personally examine the individual,
- sign, in writing, a statement specifying that the individual has an incapacity; and
- append this statement to the power of attorney health care form.

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The certifying physicians cannot be related to the individual nor be an heir of the individual's estate.

The decisions of the health care agent have priority over those of all other individuals, except those of an individual (principal) who has not been certified as having an incapacity and those of a guardian appointed by the Court, unless the Court declares that the power of attorney for health care remains in effect.

Are there limits to the decisions a health care agent can make?

The health care agent is required to act in good faith consistent with the desires of the individual as expressed in the health care instrument or as otherwise specifically directed by the individual to the health care agent at any time. However, according to s. 155.20, Stats., the health care agent may not:

- Make any health care decisions for an individual who is pregnant if she has not extended authorization to cover periods of pregnancy in the power of attorney health care instrument.

- Authorize experimental mental health research, psychosurgery, electroconvulsive treatment or other drastic mental health treatment procedures;

- Consent to the withholding or withdrawing of orally ingested nutrition or hydration unless provision of such is medically contraindicated;

- Consent to the withholding or withdrawing of non-orally ingested hydration or nutrition unless authority for this is specifically granted in the health care instrument and the attending physician, in his or her professional judgement, advises that the withholding or withdrawal will not cause the individual pain or reduced comfort. Note: Even if a person authorizes the withholding or withdrawal of hydration or nutrition and the physician has advised that this will not cause pain or discomfort, hydration or nutrition cannot be withheld if the individual executed a power of attorney for health care *prior to December 11, 1991* and has a valid living will executed under *earlier versions* of chapter 154. A living will executed under *earlier versions* of chapter 154 does not allow any form of hydration or nutrition to be withheld and takes precedence of the instructions authorized in a power of attorney for health care instrument *that was executed prior to December 11, 1991.* (s. 155.70(3), 1989 Stats.) See page 6.

- Consent to inpatient admission of the individual to any of the following:

  - an institution for mental diseases, as defined by statute;

  - an intermediate care facility for the mentally retarded, as defined by statute;

  - a treatment facility, as defined by statute;

  - a nursing home, as defined by statute, unless one of the following applies: (1) the admission occurs directly from a non-psychiatric hospital and is for

recuperative care for a period not to exceed three months; (2) the individual lives with the health care agent and admission is temporary (not exceeding 30 days) in order to provide the health care agent a vacation or a release for a family emergency; (3) authority for admission is specifically granted in the health care instrument and the principal is not diagnosed as being developmentally disabled or as having a mental illness at the time of the proposed admission.

- a community-based residential facility, unless the exceptions noted for nursing home admission apply.

Persons 18 years of age or older and of sound mind who voluntarily wish to designate a power of attorney for health care must sign and date the power of attorney for health care document in the present of <u>two witnesses</u> who:

- are 18 years of age or older;
- are unrelated to the individual by blood, marriage, or adoption;
- are not, to the best of their knowledge, entitled to or have claim to any portion of the individual's estate;
- are not health care providers (licensed nurse, chiropractor, dentist, physician, podiatrist, physical therapist, occupational therapist, occupational therapy assistant, optometrist, psychologist, a person practicing Christian Science treatment, a partnership or corporation of the above that provides health care services, a home health agency, or a cooperative sickness care plan that provides services through salaried employees in its own facility) serving the individual at the time power of attorney authority is granted;
- are not directly financially responsible for the individual's health care; and
- are not the designated health care agent.

If an individual who is appointing a power of attorney for health care is unable to sign the form, the power of attorney for health care form may be signed and dated, at the express direction and in the presence of the individual, by a person who is at least 18 years old.

<u>What takes precedence, a living will or a power of attorney for health care?</u>

This applies to persons with both a living will and a power of attorney for health care.

In some cases, a living will takes precedence over conflicting provisions in a power of attorney for health care instrument and, in other cases, a power of attorney for health care instrument takes precedence over conflicting provisions in a living will, depending upon when the documents were executed.

- *A power of attorney for health care instrument executed after December 11, 1991, supersedes conflicting provisions of a living will no matter when the living will was executed.*

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- *A living will executed under earlier versions of chapter 154 supersedes conflicting provisions of a power of attorney for health care instrument executed prior to December 11, 1991.*

- *If a person has a living will executed under the revised 1991 statute and a power of attorney for health care instrument executed prior to December 11, 1991, it is not clear from the statutes which would take precedence if conflicts arose between the two. We have brought this to the attention of the Legislative Reference Bureau which helped draft the revisions to the statutes. To minimize possible confusion of one's intentions, persons falling into this category may wish to execute a new power of attorney for health care instrument or revoke one of the documents.*

Uniform Durable Power of Attorney

The Uniform Durable Power of Attorney (UDPOA), as originally enacted, had an effective date of May 1, 1982. It may be a valid means to have designated a health care agent if it was executed prior to April 28, 1990 (the effective date of ch. 155, Stats.) and meets the provisions noted below. A UDPOA executed after April 28, 1990 is not a valid way to designate a health care agent *unless that portion of the instrument conforms to the requirements in s. 155.30(2), Stats. One way a UDPOA may conform to s. 155.30(2), Stats., is to contain the statement; "I am a lawyer authorized to practice law in Wisconsin. I have advised my client concerning his or her rights in connection with this power of attorney for health care and applicable law.".*

A UDPOA executed prior to April 28, 1990 still is valid if it specifically designates an agent to perform in the event of an individual's incapacity and if it contains words similar to "this power of attorney shall not be affected by subsequent disability or incapacity of the principal". No other formulation requirements existed to delegate health care decisions.

The Uniform Durable Power of Attorney was used primarily to designate an individual (called an "attorney-in-fact" in the statute) to carry out personal or business financial transactions in the event of an individual's incapacity. It was used less frequently to designate a health care agent.

A properly completed uniform durable power of attorney form authorizes the attorney-in-fact/health care agent to accept, maintain, discontinue or refuse health care options if the individual (the principal) becomes unable to do so. However, the attorney-in-fact cannot place a declarant in a nursing home.

Introduction to Wisconsin Medicaid State Plan Amendment - OBRA Enforcement Sanctions and Related Provisions

(Effective July 1, 1995)

The Omnibus Budget Reconciliation Acts (OBRA) of 1987 and 1991 amended the Social Security Act revising Medicaid law relating to nursing home survey, certification, enforcement and related matters. The revised Section 1919(h) of the Act resulted in final regulations, issued on November 10, 1994 and effective on July 1, 1995. These regulations implemented the enforcement or compliance provisions for Medicaid participating nursing facilities (NFs), as well as certain related provisions. The related guidance for compliance with federal requirements for the implementation of these OBRA provisions was distributed under cover of Transmittal No. 273 of the State Operations Manual (SOM).

This plan represents the state's intent to comply with the federal enforcement remedies as specified in 42 CFR Part 488 and utilize "additional remedies" as authorized under 42 CFR 488.303(e). This plan also includes representations or clarifications regarding State Medicaid Agency and State Survey Agency compliance with OBRA-related provisions, based upon the final published November 10, 1994 regulations, requiring State Plan language as explained below.

This Plan submittal adopts the preprint (HCFA PM-95-4) sent to State Survey and Medicaid Agencies by HCFA. However, review of the pertinent final federal regulations published November 10, 1994, as well as the related State Operations Manual Transmittal No. 273, and finally the State Plan preprint format revealed that certain OBRA-related requirements could not be accommodated within the confines of the prescribed preprint format. Therefore, this agency is addressing related and required provisions as follows in this introductory section. These OBRA enforcement-related provisions pertain to:

1. enforcement remedies for ICF-MRs;
2. disclosure of survey information requirements;
3. nursing facility complaint procedures;
4. nursing facility appeals options; and
5. enforcement remedies for State-operated NFs.

1. *Certification and Enforcement Remedies for ICF-MRs*

A statement regarding certification for ICF-MRs is included in this plan for the following reasons. HCFA PM-95-4 replaces page 79c of the HCFA-approved Wisconsin Medicaid Plan. Page 79c refers to the enforcement plan as applying to NFs and ICFs which, by definition, includes ICF-MRs. Part 488 of the regulations deals with NF enforcement remedies.

HCFA-PM-95-4, the State Plan preprint transmittal, addresses OBRA-related certification and enforcement for NFs only. The transmittal does not include ICF-MRs or State-operated NFs. Section 488.330 states that HCFA certifies the compliance or noncompliance of all State-operated facilities. There is no corresponding State plan provision needed to implement this provision. However, the November 10, 1994 final federal regulations also state that two enforcement remedies apply to ICF-MRs. Moreover, 42 CFR 442.100 requires that the State Plan meet the requirements of 42 CFR Subpart C, Certification of ICF-MRs and Part 483.

Since HCFA-PM-95-4 instructs the states to delete page 79c of the current approved State Plan and replace it with the new preprint which does not address ICF-MRs, adoption of the preprint would leave the State Plan without ICF-MR enforcement and certification provisions. Therefore, Wisconsin is including the 42 CFR 442.100 statement for ICF-MRs in this introduction as follows:

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Wisconsin will continue to comply with the certification and enforcement provisions of 42 CFR Sections 442.101, 105, 109, 110, 117, 118, and 119 for facilities certified under Section 1919 of the Social Security Act as Intermediate Care Facilities for the Mentally Retarded (ICF-MRs). For ICF-MRs, Wisconsin is adopting the enforcement remedies of termination under Section 442.117 and denial of payments for new admissions under Section 442.118 to be applied using the criteria specified in said sections.

2. ***Disclosure of Survey Information Requirements.***

The November 10, 1994 final federal regulations amended Section 431.115 relative to State Plan requirements for disclosure of survey information and provider or contractor evaluation. Paragraph 431.115(c) now reads, "State plan requirements. A State plan must provide that the requirements of this section and 488.325 of this chapter are met." To meet this requirement, Wisconsin is resubmitting the exact language from HCFA-AT-80-38 and approved by HCFA on 9/26/80, effective 7/1/80, and submitting an amendment to page 79w of the State plan which expands upon paragraphs (r), (s), (t), and (u) of page 79w.

Disclosure of Survey Information and Provider or Contractor Evaluation

HCFA-AT-80-38: **The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.**

Amendment to Page 79w of State Plan. The following language was circulated to the public as part of the State's draft Plan revisions on June 30, 1994 and remains unchanged. This is an amendment to paragraphs (r)-(u) of page 79w to bring the plan into compliance with the November 10, 1994 final federal regulations.

The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies and providers' comments, a list of isolated deficiencies that constitute no actual harm, with the potential for minimal harm, approved plans of correction, statements that the facility did not submit an acceptable plan of correction or failed to comply with the conditions of imposed remedies, final appeal results, notice of termination of a facility, Medicare and Medicaid cost reports, names of individuals with direct or indirect ownership interest in a facility, and names of individuals with direct or indirect ownership in a facility, as defined in 42 CFR 420.201, who have been found guilty by a court of law of a criminal offense in violation of Medicare or Medicaid law.

The department provides the State's long-term care ombudsman with a statement of deficiencies reflecting facility noncompliance, including a separate list of isolated deficiencies that constitute no harm with the potential for minimal harm, reports of adverse actions specified in 42 CFR 488.206 imposed on a facility, written responses provided by providers, and providers' requests for appeals and the results of any appeal.

The department provides written notice of substandard quality of care at a facility to the attending physician of each resident in the facility with respect to which a finding of substandard quality of care was made, and to the State board responsible for licensing the facility's administrator.

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The department provides access to any survey and certification information incidental to a facility's participation in Medicare or Medicaid upon written request by the State Medicaid fraud unit, consistent with State laws.

3. ***Nursing Facility Complaint Procedures.***

The implementing State Operations Manual (Transmittal 273 issued June, 1995) for the OBRA enforcement regulations specify State plan criteria and requirements. This plan submittal in its entirety addresses each applicable provision unless there is an existing and approved State plan provision. For instance, Section 7700 of the State Operations Manual requires that, relative to 488.332, the State plan must describe the State's procedures for processing complaints. Since the November 10, 1994 regulations did not amend these provisions and since Wisconsin has a plan amendment approved by HCFA 4/1/93, and effective 7/1/92, which complies with the applicable requirements, we conclude that there is no need to revise the State plan relative to complaint procedures. This conclusion was concurred with by HCFA during the State plan public review period. The applicable State plan provision is TN #92-0024, page 79w of the Wisconsin Medicaid Plan, paragraph (q) and Attachment 4.40-E.

4. ***Appeals Options for NFs and ICF-MRs***

The November 10, 1994 regulations amended Subpart D, 42 CFR 431.152 by requiring that, "The State plan must provide for appeals procedures that, as a minimum, satisfy the requirements of 431.153 through 431.154." The pertinent existing Wisconsin State plan provision is found on page 76 of the plan (TN# 93-017) with an approval date of 6/16/93 and an effective date of 4/1/93. This transmittal was a preprint assurance which would satisfy the requirements of Sections 431.153 and 431.154 published in the November 10, 1994 federal regulations with the following revision to page 76 of HCFA-PM-93-1 of the Wisconsin plan in section 4.28(a):

The Medicaid agency has established appeals procedures for NFs and ICF-MRs as specified in 42 CFR 431.153 and 431.154.

5. ***Enforcement Remedies for State-Operated NFs.***

HCFA-PM-95-4, the State Plan preprint transmittal, addresses OBRA-related certification and enforcement for non-State-operated NFs. The transmittal does not include State-operated NFs. The plan being replaced does include State-operated facilities. Section 488.330 states that, "HCFA certifies the compliance or noncompliance of all State-operated facilities." There is no corresponding State plan provision needed to implement this requirement. The status of State facilities is addressed in this introduction since the State-operated NFs were included in the plan being replaced by this submittal; and this agency wishes to address the State facilities (and ICF-Mrs above) for completeness such that the combination of this summary and the preprint transmittal cover <u>all</u> Medicaid-certified facilities as did the approved preceding plan (TN#91-013) from July, 1991, through the present.

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